CLOSER TO HOME

Canadian Cataloguing in Publication Data
British Columbia Royal Commission on Health Care and Costs.
Closer to Home
ISBN 0-7726-1426-1
Contents: v.1. Summary of the Report of the British Columbia Royal Commission on Health Care and Costs - - v.2. Report of the British Columbia Royal Commission on Health Care and Costs - - v.3. Sources for the Report of the British Columbia Royal Commission on Health Care and Costs.
1. Medical care - British Columbia. 2. Medical care, Cost of - British Columbia. I. Title.
RA412.5.C3B74 1991 362.1'09711 C91-092313-2

CLOSER TO HOME

SUMMARY OF THE REPORT OF THE BRITISH COLUMBIA ROYAL COMMISSION ON HEALTH CARE AND COSTS

the
COMMISSIONERS

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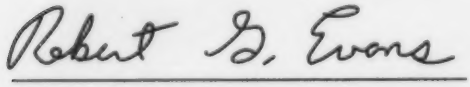

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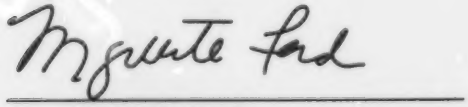

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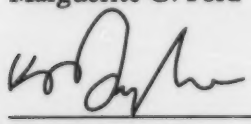

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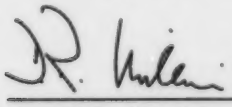

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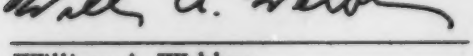

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VOLUME 1
PHOTO ACKNOWLEDGEMENTS

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The British Columbia Royal Commission on Health Care and Costs

November 5, 1991

His Honour,
The Honourable David C. Lam,
Lieutenant-Governor, Government of British Columbia,
Government House,
1401 Rockland Avenue,
Victoria, BC.

Your Honour:

We take pleasure in submitting *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs.* Although we take responsibility for the report and its recommendations, the work is not ours alone. In eighteen months, we received close to 1,500 submissions, talked to hundreds of people and sought information and advice from a variety of sources. We would like to record our appreciation to these people, to the researchers who worked for the commission and to our staff.

In June of this year, we published *A Great System, But...* That document summarized what the people of British Columbia told the royal commission in public hearings and in written submissions about the system of health care in this province. It *is* a great system, staffed and run by dedicated, talented people, but...

According to the submissions, there is a lack of direction in health care in BC. There is a lack of local influence complicated by a heavily centralized bureaucracy with a pervasive sense of secrecy that separates it from the people it serves. Again and again, individuals, organizations and the representatives of institutions — even employees of the Ministry of Health — told us that the system is littered with barriers that reinforce inequities, kill initiative and stifle changes.

And changes are what the submissions speak mostly about: changes to the philosophy of care; changes to legislation and educational qualifications, standards and mandates; changes in the influence various professions have over the system; changes in accountability and accessibility; changes to improve the system, to make it more flexible and more representative of the health care needs of British Columbians. Changes to increase personal independence, support self-esteem and ensure that people get the right care in a timely and caring way.

The commission has carefully studied the submissions we received. We have listened to the arguments, researched different options and been deeply moved by many of the things that we have heard. And we have come to the conclusion that the perception of the people who spoke to us is correct: it is a great system, but it needs to change.

We do not want there to be any doubt about what we are saying. We have walked the halls of many hospitals, talked to many people and have seen examples of excellent work at all levels in the system. We have seen caring and compassionate home care workers, efficient

and effective emergency departments, outstanding organ transplant teams and exciting, progressive research. We recognize that health care in British Columbia is part of a system and the people who work within it can be proud of the way in which they carry out their obligations to the global community. We support quality and innovation at all levels of the system and encourage the development of new knowledge and programs. And we accept that, where British Columbians have special expertise, they should provide training and care to people from elsewhere, as long as they first satisfy the needs of the people of the province.

But too often those needs go unmet. Too often creative and cost-effective solutions to health care problems — particularly problems in the delivery of services — are opposed by a fortress mentality that equates change with threat, shifts in priorities or reallocation of funds with cutbacks, and integration and accountability with a loss of control.

We are unanimous in our opinion that the system of health care in this province is one of the best, and quite possibly the best, in the world. We do not make this claim lightly or to soothe anyone's temper. ***We have talked to representatives from many different health care systems and we have not found a system that we would accept in exchange for the one currently in operation in British Columbia***. But, there is room for improvement, and improvement will mean resetting priorities, reallocating funds and removing the fortress walls.

Because of the breadth of the commission's terms of reference (see Volume Two: *Closer to Home*) and the limited time available, we have not been able to examine everything that falls within our mandate. Instead, we have generally concentrated on the structure of the health care system. We have, on occasion, suggested that a topic, such as no-fault insurance, is one that warrants further study by another body. In the same vein, we have not attempted to deal with issues that have been dealt with or are being dealt with by other commissions or committees, such as The Royal Commission on New Reproductive Technologies or the BC Guardianship Committee. There are also a number of areas in which our own studies have not led to any specific recommendations and, therefore, are not discussed in this report.

Many of the submissions ask the commission to provide special help for members of a particular group or people suffering from a particular disease or condition. Many request special provisions under Pharmacare or Home Care for the groups that they represent. But we believe that the best care possible can and should be provided to all British Columbians, regardless of their age, sex, place of origin, disability or illness.

Many of the people who made submissions to the commission have adopted the 1984 World Health Organization (European Region) definition of *health* as *the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment.* Others support the 1986 Ottawa Charter for Health Promotion definition of *health* as *a resource for everyday life.*

We understand these definitions, and our experiences over the last year and a half have convinced us that the social and economic environment is a critical determinant of human health. For the purposes of our report, though, we have concentrated on the fields set out in our terms of reference. We believe that this focus is essential and that the changes we are recommending are both pragmatic in nature and achievable in scope.

Medicare is not a luxury.
UNI-083

The Five Principles of Medicare

In 1984, the Canada Health Act defined and reaffirmed the five principles of medicare as expressed in The Royal Commission on Health Service, 1964, chaired by Justice Emmett Hall. The British Columbia Royal Commission on Health Care and Costs fully endorses these principles, which are:

- comprehensiveness
- universality
- portability
- accessibility
- public administration.

To date, no Canadian province has confirmed the five principles of medicare by enacting them in legislation. Every province has taken steps to discourage or prevent extra-billing and has removed hospital user fees, but none has gone further. ***We believe that it is important that the BC government take the first step and make these principles an integral part of BC law.***

There is more to health than health care.
SOC-006

The Guidelines

By talking with British Columbians and listening to their concerns and aspirations, we have arrived at a set of simple guidelines which, along with the five principles of medicare, we believe are necessary components of a health care system. We think that anyone studying the matters brought before us would come to the same conclusion.

- *Closer to Home*

Medically necessary services must be provided in, or as near to, the patient's place of residence as is consistent with quality and cost-effective health care.

- *The Public First*

Public servants and professional colleges must always put the public interest ahead of their own or their members' interests.

- *Outcomes*

The focus of the health care system must be on providing those services which improve health outcomes. These outcomes must be defined, measurable, subject to analysis and be able to be independently evaluated. Services which cannot be shown to improve health outcomes should not be funded by the health care system.

- *Community Involvement*

Decisions should be made as close to the community level as possible; local people must be allowed to shape the local system of health care delivery. Government should be prepared to fund coordinators and to encourage the creation of advisory boards. If government attempts to force local citizens to participate in schemes designed by the Ministry of Health, the boards will be failures.

• *Funding*

The people of British Columbia must reform and improve the health care system within the current levels of spending. At the same time, government must recognize that although provincial revenues may vary, sickness does not. There must be less variability in the funding of health care than there is in other areas of the provincial budget.

• *The Jericho Process*

Administrative walls within the Ministry of Health, among all ministries, health care institutions and organizations, and between all of these groups and educational institutions, must be broken down in favour of an integrated health care system.

• *Necessary Education*

All tasks within the health care system should be open to people with the education necessary to provide high-quality care. People should not be barred from performing a task because they lack education which is not necessary to performing that task and does not demonstrably improve health outcomes. The "credentialization" of positions within the health care system must be stopped.

• *Volunteers*

Citizens who volunteer help are a significant part of the health care system and are vital to developing new programs. People have the right to participate directly by volunteering their time in appropriate roles that include governance, patient service and advocacy, but not by replacing paid staff. Neither should paid staff or their representatives seek to replace volunteers. Volunteers should have some control over the jobs that they do. During labour disputes, essential services agreements should identify appropriate volunteer roles.

• *Openness*

Except where privacy and confidentiality demand otherwise, all of the information on health and health care gathered by public servants in ministries and in publicly funded institutions should be available to the public and researchers. Secrecy breeds suspicion. It shows a lack of respect for the public. Openness can foster credibility, understanding and acceptance.

Changing Roles and the Health Care System

In the past, people relied on physicians to provide or direct almost all of their health care. There were few machines, few drugs and few specialists. The family physician was given and assumed responsibility for the health of most people, the direction of nurses and volunteers, and the control of the hospital system. Taxpayers were involved, but only marginally: government was on the fringes and the responsibility for paying for medical services was borne by the individual.

Today's problems come from yesterday's solutions...
MUN-020

But all of that has changed.

There are now almost as many specialists as there are family physicians in BC. Machines and medications have fuelled a medical revolution and many highly trained people now use expensive technical devices that not only aid physicians, but, in some instances, replace them. Women no longer accept the roles that the traditional health care system once expected them to play.

Nor is the physician now the only person qualified to decide on what treatment or studies are appropriate for a patient. In the past, no one else was involved in these questions but now there are technicians, therapists, pharmacists and, increasingly, community groups, volunteers and informal caregivers. Taxpayers, represented by government, are also no longer on the fringes.

This is a time of change,
and people do not like to change.
This is human nature.
UNI-041

Health care in British Columbia employs more than 60,000 people and it costs more than $850,000 an hour. The majority of this money is raised through taxes and spent by the government, as directed by the people. Possibly more than any other single factor, this legislated responsibility has changed the role of the physician and the individual in the control of the health care system. The constraint once found in the individual's ability and willingness to pay has been replaced by the constraint of collective bargaining and the government's ability and willingness to pay.

It is often difficult to accept a change in role, particularly for professional people. It can also be difficult for the public to recognize that roles and responsibilities, including its own, have changed. But changes have occurred. And what is left is to reorganize the system accordingly.

Seniors and the Health Care System

Because of the recent work by the BC Task Force on Issues of Concern to Seniors, and because such a large number of the topics discussed in this report relate directly to seniors, we have not written a separate chapter for them. Instead, we think that the reader should be aware continually of the effect an aging population has upon the mandate, structure and funding of health care services. We also want to emphasize that independence, self-esteem and the quality and value of life are not the concerns of any one age group or sex. They are important to everyone.

The need to move medical services closer to home and the need to involve the community in its own health are particularly important issues for seniors. Policies and programs which help people

in communities to look after their neighbours are an important part of this process and require a system in which information, subject to the requirements of privacy and confidentiality, is freely available. ***The government must not discourage neighbourly support***.

In the course of our hearings, people from several communities described approaches to health promotion in which seniors, youth, people with disabilities and Native people were directly involved in identifying and responding to their own health care needs. We agree with these community-based approaches. And bearing what we have heard and seen in mind, we have concluded that health care services and programs for seniors and the frail elderly should be characterized by:

- the maximum degree of autonomy
- a continuum of care including the home, the community and, if necessary, institutions.

• *Toward a Better Age*

We have reviewed the report of the BC Task Force on Issues of Concern to Seniors, *Toward a Better Age*, and considered the 21 recommendations set out in the section titled "Toward Health and Wellness". Many of these recommendations touch upon or overlap recommendations made in this report. The Task Force supported multi-level health care facilities, psychogeriatric care, training in psychogeriatrics, training in remote parts of the province, assisted travel, hospital outreach and hospital community programs, home support, palliative care, drug and alcohol programs and programs that encourage good health.

We agree with the thrust of these recommendations, subject to two general cautions. Emphasis should be placed on reallocating funds and appropriate analyses of health outcomes must be undertaken

We need
a comprehensive plan for the care
of the elderly
to be put together
for the province
as a whole.
PRO-014

Economic Profile

The cost of health care is usually described in relation to the budget of the provincial government, because nearly 70 percent of all health care expenditures are paid for through the provincial government. Advocates of new programs or expanded services usually want government to increase its spending; opponents worry about the level of taxation and the size of the provincial deficit. But government, though often at the centre of the stage, is only one part of the overall provincial economy. Its estimated expenditures in 1990/91 of $15.3 billion is less than one fifth of the $81.1 billion in economic output and income (Gross Provincial Domestic Product) generated in the province as a whole. It is the size and rate of growth of the provincial economy which determines British Columbians' ability to pay for health care, and from which the revenues of the provincial government are drawn.

If the provincial economy is healthy, then government revenues will be ample and the health care system can maintain itself or expand without straining financial resources. But if the economy stagnates or declines, the government's revenue is reduced and some combination of deficits, increased taxes and program cutbacks follows. Private funding is not a way out of this circumstance. In the face of slow growth, transferring the costs of programs from government to private budgets does not make them more affordable, it just charges them to someone else.

In BC, the central economic fact of the last decade has been the decline in the rate of growth of the provincial economy. 1961 to 1981 was a period of sustained, rapid growth and the Gross Provincial Domestic Product per capita (adjusted for inflation) grew at an average annual rate of 3.7 percent. But the 1980s began and ended with recession, and the recovery in between was slow and weak. From 1981 to 1990, the average annual rate of growth in output per person was only 0.5 percent.

The frail economic recovery in the late 1980s, combined with the restraint policies of the provincial government, moved the provincial government budget back to a small surplus. But the 1990/91 recession has brought back deficits. And current forecasts for an early recovery from this latest recession predict growth rates during the first half of the 1990s far below those achieved in the 1960s and 1970s – not much above one percent per year at best.

If these forecasts turn out to be accurate, there will be little or no scope for overall expansion in government expenditures,

other than through increases in taxation or debt. The federal Government Expenditure Restraint Act of June 1990 further narrows the province's room for fiscal manoeuvres by reducing the level of federal cash transfers for health and education. These transfers made up about $2 billion of the BC government's $15.3 billion in revenues in 1990/91.

In this environment, expanding programs in health care, or anywhere else, will require shifting resources from other programs. The record suggests, however, that actually transferring resources is difficult. Even pronounced changes within the health care sector tend to be cancelled out over time.

Between 1980/81 and 1981/82 there was a large and sudden swing of about 3.5 percent of the provincial health budget from hospitals to physicians. But this has slowly been reversed and, by 1990/91, the hospital share was just above its 1980/81 level. A similar fall and rise occurred for Continuing Care; the share at the end of the decade is almost the same as at the beginning. Medical Services Plan (MSP) payments to physicians and others have declined for a number of years after an initial surge, but, up until 1989/90, their share was still greater than the one that they held at the beginning of the decade. Community and Family Services have had a sustained gain during this period, from just over 5 percent to just over 7 percent, which represents a large change for a small set of programs, but not a major reallocation of the health care budget.

Thus, while each sector share fluctuates from year to year, over a period as long as a decade they even out. Even the share of provincial government spending going to health is almost constant – between 30.6 percent and 33.2 percent – and the share of the provincial product going to government spending has fluctuated only with the business cycle. It appears, therefore, that in a zero growth environment, each program has managed to hold on to its share. In the Chinese idiom, each group of providers has received an unbreakable *iron rice bowl.*

If slow overall growth continues through the 1990s and no changes occur in the organization of the delivery of health services in BC, this rigid pattern will presumably continue. Under these conditions, the money available for health care will only increase if the province goes further into debt, or increases taxes. We do not believe that the people, or the government, of British Columbia would find either of these options acceptable.

The commission has been told that there are a number of priorities that need to be met. If they are to be met — and we believe they should be — then the inflexibility of the past cannot persist. The money now spent on health care must be used more effectively; some shares must fall and some rice bowls must be broken.

Home care cannot lower the total system costs unless its growth is accompanied by actual reductions in the supply of institutional services. We cannot continue to add on and add on.
HUT-006

The fact is that when you get 1 in 10 workers in our economy working in this industry, all of those who make a buck out of it want to expand the size of the market.
IND-073

A Provincial Health Council

We shall remain a forward-looking place, and a people who wish to lead, rather than follow, through this time of change ...
HOS-074

The system of health care which we have studied for the past year and a half developed from various programs and policies which were created or changed to meet the political as well as the medical needs of the day. ***There has never been an overall plan, and, quite naturally, the structure that has evolved lacks coherence and sometimes logic.*** It also lacks the ability to assess itself and to objectively judge how just, efficient and effective it is in providing health care. How it manages to operate is a mystery, even to the Auditor General, as he pointed out in his 1988 *Annual Report*.

According to a number of submissions to the commission, the province needs the guidance of a permanent, independent council. We agree. In our opinion, such a council should be able to oversee the total health care system and be able to review the policies, plans and programs of the Ministry of Health, or of any other public or private body whose actions affect the health of British Columbians. It should be able to inform the public of how well the government is meeting the health care needs of the province and, as one commissioner put it, "soften the political side" of contentious questions, bringing its influence to bear upon difficult, high-profile issues. ***It must be completely independent of the government, the Ministry of Health and the health care industry***. It should:

- enunciate specific goals for the health care system
- evaluate information to determine the degree of progress in reaching these goals
- advise the government, when requested or on its own initiative, on contentious issues
- review and comment on the health policies and plans of the Ministry of Health or of other ministries
- assess the effectiveness of all parts of the health care system, including the evaluation component
- ensure that authoritative health information is easily available to the public
- direct the provincial health officer to investigate or research public health concerns.

But we want to be perfectly clear: ***the royal commission does not question the ultimate power of the Legislature to make decisions about the health care system. That power is at the heart of our democratic system and should not be challenged***.

We considered the possibility of a medical ombudsman's role for such a council, but have decided the role should reside elsewhere. The current Ombudsman's Act, passed in 1979, contains provisions, as yet unproclaimed, that would extend the Ombudsman's authority to hospitals, boards

of management of hospitals, and to governing bodies of professional and occupational associations. These provisions would not displace the responsibility of colleges for professional matters, but they would permit investigation of complaints about the health care system and reports on how it provides services. We favour concentrating the ombudsman's role in an office which has already established its legitimacy by proclaiming those provisions.

If a health council is to have authority and credibility, the selection of its members and chairperson will be critical. They must be independent, objective and influential, have security of tenure, a small staff, the power to contract for services and the responsibility to make an annual public report. They would need to have access to all of the information available to the Ministry of Health and other ministries, institutions and organizations.

It is time for a provincial health council. ***It must be a creature of and report to the Legislative Assembly, not the Ministry of Health***.

Public Policies for Health

The traditional focus of our health care system is the curing of illness and not the prevention of injury and disease. In 1988/89, ninety-seven percent of the Ministry of Health's budget was spent on institutional care, medical services and Pharmacare. Less than 1.5 percent was spent on services such as health promotion, public health nursing and inspections, nutrition, speech and hearing programs.

It is time to change this focus. Increased spending for hospitals, equipment or health care will not necessarily improve health status. More money should be spent on the prevention of illness or injury and on protecting health. The least amount of money possible should be spent on providing the necessary, high-quality curative services. If British Columbians want to continue to improve the quality and healthy duration of their lives, they must ***pay more attention to areas outside of the health care field***.

Poverty, for example, is intimately associated with poor health. More than four years' difference in life expectancy exists between the lowest and highest income levels in Canada, and more than 11 years' difference in disability-free life expectancy. Health is also influenced by early childhood experiences, the nature and availability of housing, an individual's employment status, hazards in the workplace and environmental pollutants, family and community support and self-esteem.

We've reached a state in Canada where medical bills don't make people poor. We haven't reached the state where poverty doesn't make people sick.
IND-073

It is time to recapture the *public* component of public health and stop the drift toward the American system of care with its focus on individual rather than on public good.

Strategies for Change

- Direct the provincial health officer and the province's medical health officers to be more vocal in their support of the public's health and to work with the Provincial Health Council to investigate public health concerns.
- Establish a set of measurable health indicators with which to plan and evaluate public policies for health.
- Develop educational support for immunization programs as well as a no-fault insurance policy to cover all vaccine associated injuries and dedicate resources to stop the spread of sexually transmitted diseases.
- Evaluate the possible health effects of all proposed provincial programs or legislation, or changes to existing programs or legislation.

Enabling people to make their own health care decisions is indeed healthy public policy.
PRO-012

- Institute public health initiatives including: the mandatory use of bicycle safety helmets; the expansion and improvement of bicycle pathways and the inclusion of bicycles in the transportation plans of all levels of government; the reduction of the allowable blood alcohol content for motor vehicle operators to a maximum of 0.04g/dL; brakes on all wheels on commercial vehicles licensed to operate in BC.
- Include studies of potential health effects in all environmental impact assessments.
- Increase support for the healthy communities movement.

The Best Care

Providing the best care possible depends upon a number of things including access to comprehensive data on what care is provided by whom, to whom, for what reasons, at what costs and *with what results.* Yet, currently, there is no standard recording of the state of patients upon admission and discharge from hospital, or of the effects of procedures upon their health, unless they are re-admitted. Nor is there information on the effect care provided outside of hospitals has on the population's health.

There are many examples where information is collected in one part of the system, sent off in a report, or put in a computer never to be shared again. Good management information about utilization of the system and patterns of practice within the system needs to be shared and shared more easily.
PRO-055

This means that there is no way to assess accurately whether or not a particular medical or public health intervention should be initiated or continued, and no standard grounds on which to base professional reviews or compare the performance of different institutions.

There is also very little evaluation of the information that is collected. Is it accurate? Does it provide important answers to the questions of the day? Do the public and researchers have access to it? Do they understand it? Has it made a difference? Too often, the answer to these questions is "No." Collecting information becomes an end in itself and pertinent facts are ignored in favour of inaction or political expediency.

Strategies for Change

- Establish a consistent set of data to be collected, based upon the information the province needs, and stop collecting information which is not used.
- Expand the BC Office of Health Technology Assessment to include quality assurance and utilization review activities for the province and to establish province-wide protocols.
- Ensure that all facilities, programs and professions providing health care in BC are *required by statute* to conduct quality assurance and utilization management activities.
- Cease paying for tests or medical procedures that fall outside the provincial protocols unless there is a written explanation why a particular case is treated as an exception.
- Monitor billing practices and conduct audits through the Medical Services Commission to identify mistakes, misbillings, incompetence, misconduct or inappropriate practice. Report inappropriate practice or incompetence to the practitioner's college.
- Require the governing bodies of all health professions to respond to enquiries on the competence of any of their members.
- Ensure that there are standard policies governing the granting, suspending or revoking of the privilege to use a facility. Granting hospital privileges should be based on a review of the individual's performance and, at the outset, should be for not more than one year and, thereafter, for not more than ten years. There should be more flexibility in the nature of the privileges granted.

- Provide access to health care information on the basis of the limitations set out in the Ombudsman's report dated March, 1991.
- State clearly that the information in medical records is the property of the patient, who is entitled to a copy of the record at cost.

The Management of Health Care Services

Good management is a key to the effective and efficient delivery of health care. In British Columbia, good management is based upon knowing what is needed in Haida Gwaii (Queen Charlotte Islands), the Kootenays and the Peace River country, as well as in southwestern BC.

A large number of people who talked to the commission feel that the present system of centralized management has failed them. They describe it as insensitive to local and regional questions, inflexible in its programs and policies, and unfair in its distribution of resources. It does not encourage the people it funds, nor those it serves, to participate in the control of the system. And while proposals for operating budgets and new services come from hospitals and local communities, all of the monetary decisions occur in Victoria. In a province as diverse as British Columbia, it is not surprising that, as a result, many people feel that "Victoria does not understand our needs."

The organization of tertiary care in the province and waiting lists for surgery and other procedures are also directly tied to how the health care system is managed. The current management of the tertiary care system has been described to the commission as lacking goals, being unaccountable to the public, being poorly planned, poorly organized and poorly distributed. It is described as insensitive.

Strategies for Change

- Divide the province into several health regions, each with a regional general manager recruited for managerial skill and experience, not necessarily for experience within the health care system. The regional general managers must work within the regions, be responsible for setting local goals and oversee regional health care personnel plans, regional budgets and the allocation of resources within the region.
- Assign each region a funding envelope which contains all of the health care dollars for that region with the exception of funding for programs administered out of Victoria.
- Leave the planning of province-wide standards and programs, and the funding for province-wide services, such as tertiary care, in Victoria.
- Support the creation of local and community boards to advise the regional general managers on the allocation of resources within their area. These boards should be allowed to define their own structure; they will not work if membership is imposed upon them.
- Publish proposed regional budgets and encourage and allow time for consumer and provider groups to advocate changes.
- Create teams to link programs and ministries within a region to ensure coordination between the programs and services of the Ministry of Health and other ministries.
- Establish standards for waiting times for procedures, use them as a measure of performance and publish the results.
- Expand the new Provincial Surgical Registry and make it into a surgical and diagnostic registry. This should include a computerized waitlist showing the availability of hospitals and specialists and the waiting time for procedures. All of this information should be publicly available, subject to minimum restrictions.

The existing structure of funding and administration of health care funds has not provided integrated planning of service delivery, health education or health promotion at the regional level.
HUT-024

Alternative Delivery Organizations

Alternative health service delivery organizations, such as community health organizations, have had little success in establishing themselves in BC. There is extensive literature supporting their use in particular situations and some evidence that, if they are funded and staffed correctly, they can reduce the number of hospitalizations. There is also some evidence that the traditional opposition of physicians to alternative health service delivery organizations is fading.

Strategies for Change

- Actively support the development of alternative health service delivery organizations by coordinating policies, procedures and, possibly, legislation.

We believe that there is
enough evidence and track record that
community health centres
can reduce institutional costs
and maintain the quality of care.
This alone should be
of interest
to the government.
SOC-155

Health Care Services in Rural and Remote Areas of BC

Over one-quarter of the submissions sent to this commission came from people living or working in rural or remote BC. People in these areas suffer from higher than average rates of infant deaths, accidental deaths, alcohol related deaths and violent deaths. At the same time they have fewer health care workers, fewer psychiatric beds and no alcohol or drug detoxification centres.

Health care workers are difficult to recruit and retain in much of the province. As one person stated to the commission, *"We have no permanent radiologist. We have no internist. We have no paediatrician, obstetrician or gynaecologist. No pathologist. We have no psychiatrist." (HCP-063)* The list could include speech therapists, audiologists and psychologists.

The ability of hospitals to provide basic medical services in rural and remote parts of the province is threatened by these shortages. It is also threatened by changes in the hospital funding base resulting from people travelling out of their communities to get the services the local hospital can no longer provide. In 1989, almost 22 percent of the cases seen in rural and remote communities were referred to hospitals in urban or metropolitan centres. This need to travel can be a barrier to proper health care that directly affects individuals and families and, in turn, affects the economic health of an area, influencing business and education decisions.

Strategies for Change

- Create positions for rural residents to train as rural health care workers, move a number of internships and residencies to locations in rural and remote BC and fund rural specialties.
- Create a recruitment and retention program similar to Ontario's Underserviced Area Program.
- Expand the Northern Isolated Area Travel Allowance Program to include a travelling health care worker program.
- Create a communications program similar to Newfoundland's Memorial University Telemedicine Program, including remote access to computer data banks on health care literature, medical data transmission and telewriters.
- Encourage the establishment of hostels associated with large metropolitan hospitals.
- Encourage resource sharing by developing inventories of services.
- Revise the regulations so that health care personnel can work in several fields.
- Establish a grant program to help rural hospitals become integrated health care centres.
- Establish a central dispatch office to secure hospital beds and provide hostel accommodation for patients from rural and remote areas.
- Establish a travel grant program for people who must travel to receive health care.

The loneliest caregiver
is a primary nurse
serving a remote community alone.
HCP-065

He (dispatcher) told me "they would not allow this, that he must stop in Mackenzie". I explained that the extra 25 minutes of flying time required to Prince George was far more valuable than an assessment in Mackenzie from where he would be sent to Prince George anyway. He told me "sorry, that's the way we do things".

Letter from physician

Ambulance Services

The Emergency Health Services Commission operates, without a doubt, one of the finest ambulance services in the world. However, like many other aspects of the health care system, there is room for improvement, particularly in rural and remote BC.

Most difficulties arise from inflexible policies or regulations, such as the requirement that ambulances go to the nearest hospital, regardless of whether or not that is the appropriate place for the patient to be taken. An equally perplexing problem is the Emergency Health Services Commission's unpopular insistence — supported by the Canadian Union of Public Employees — that well respected and efficient firefighter ambulance services be discontinued. It is difficult not to view this as an example of those who administer the system serving their own interest and not that of the people.

Strategies for Change

- Decentralize the management of ambulance services to the regional level while maintaining provincial standards.
- Continue and, where appropriate, expand the use of firefighter ambulance services. The Emergency Health Services Commission should bear the whole cost of training the fire fighters.
- Appoint members from communities using firefighter ambulance services to take the place of Ministry of Health personnel on the Emergency Health Services Commission.

Protecting the Principles of Medicare

The federal government passed the Government Expenditures Restraint Act in 1990. Over the next ten to 15 years this Act will significantly reduce or eliminate the cash transfer payments the federal government now makes to the provinces for education and health care. When this happens, the federal government's ability to enforce provincial compliance with the five principles of medicare will disappear. Although the principles of medicare face other threats as well, many people view the Restraint Act as the death knell of medicare.

Strategies for Change

- Enact the five principles of medicare in provincial legislation.
- Abolish premiums.
- Limit or eliminate the reduction in transfer payments and ensure that, if the transfer payments are reduced or eliminated, the provinces are given the equivalent tax room to make up the difference.

Careful Spending

The decline and possible disappearance of federal support, combined with the probability of weak economic growth over the next decade, means that the principal task facing all British Columbians is to make more effective use of the resources now dedicated to health care. As part of this process, it is necessary to consider ways of shifting resources to the activities and programs which have been identified as being of the highest priority, and limiting the growth of, or shrinking, those of lesser priority. At the same time, it will be necessary to contain the overall growth of the health care system.

A number of people in the health care field, both providers and users, believe that a decade of financial restraint has led to shortages and cutbacks in programs and services. The total proportion of the province's resources dedicated to health care is not, in reality, being cut back, it is being reallocated. Other people believe that health care costs are out of control, but the relative growth of health care expenditures in Canada has actually slowed since 1971, unlike the United States, which has seen explosive growth. Expansion in health care in BC has decreased in the wake of an economy weakened by recession and a slow recovery, but it has not ended. The expectations nurtured by three decades of rapid growth have not moderated.

The combination of competing expectations and static or diminishing resources has been well represented in submissions to the commission. If this conflict is not managed, it could lead to the collapse, or more likely the slow disintegration, of a system of health care funding and delivery which almost all British Columbians, Canadians, and increasing numbers of foreigners, regard as one of this nation's finest achievements.

The periodic debates over physicians' fees, or over wages and salaries of hospital workers, are closely linked to overall costs of health care, because such a high proportion of health care expenditures goes directly into the incomes of health care workers. The health care industry is very labour intensive.

We encourage you not to forget the health system as an engine of the economy ...
HOS-035

But there are other, less obvious forces which have powerful long-term effects on costs. For example, a recommendation in the mid-1960s to expand Canadian medical school capacity, which was not revised in the early 1970s despite dramatic changes in demographic trends, has been the major factor behind the steady increase in physician supply. That increase has been transmitted directly into increases in the use and cost of physicians' services, and into pressure on hospital and other facilities. A decision to reduce medical school placements is now urgently needed, along with steps to curtail in-migration of physicians.

The spectre of cost escalation is upon us! The affliction of cost containment confronts us!
IND-340

Any time we want to know what the cost is to treat a particular condition, we have to go back to first principles and start again, because there are no standardized consistent protocols for estimating the costs of treating particular patients in institutions
Research Forum

In the same way, decisions to fund new capital projects – build or renovate hospitals – represent the commitment of funds over a number of years. Any decision to commit funds to new capital projects carries a whole series of financial implications, and the costs associated with operating new facilities quickly dwarfs the original investment.

Many of the people involved in health care feel that such cost considerations are inappropriate or illegitimate: care is needed, it must be paid for. Yet any policies which go beyond crude expenditure ceilings and cost caps, with all the problems they can generate, will have to be subjected to wide scrutiny.

The principal task facing British Columbians is to find ways of making more effective use of the extensive resources now devoted to health care. To do this, it will be necessary to redirect some of these resources to the services and programs which provide the greatest benefit to the people of this province.

Strategies for Change

- Ensure that the growth in physician supply is consistent with the needs of the population.
- Place an absolute annual global cap on payments to physicians and hospitals. This cap should be adjusted for changes in the population and in the general price level but should not respond to other factors.
- Maintain equality between the wages and benefits of health care workers and the general wage level in BC.
- Transfer funding, over time, from the acute care hospital sector to continuing care, home care and other, less intensive institutional and residential care.
- Establish a provincial average of 2.75 acute care beds for every 1,000 people in BC.
- Transfer the long-term case load out of the acute care sector. This should include a policy that assumes that any patient in acute care for more than 30 days has been discharged to continuing care unless specifically assessed as requiring acute care. Patients deemed discharged to continuing care will no longer be included in the hospital's weighted patient day count.
- Charge continuing care patients occupying acute care beds the standard continuing care per diem rate, starting 15 days after they are deemed discharged from acute care.
- Substitute outpatient and day care services, either hospital-based or in free-standing clinics, for inpatient care.
- Develop and distribute provincial standards for patterns of care for common hospital procedures. Unnecessary services provided by a hospital should not be included in the funding formula.
- Publish the number of patients occupying acute care beds for longer than 30 days, the number of patient days being provided to them and the number that have been assessed as appropriate for acute care.
- Recruit hospital staff for expanded home care and community programs.
- Establish criteria for evaluating alternatives to hospitalization that guarantee that such programs are substitutes for hospital care and not additions to hospital care.
- Encourage and fund free-standing health facilities to provide some of the services now carried out within hospitals.
- Develop contractual agreements between facilities covering the use of technical equipment, such as magnetic resonance imagers.
- Develop contractual agreements with one or more groups to define protocols or provide certain highly specialized services on a provincial basis.

- Develop a system which will provide physicians with relevant information on the patterns of illness of their patients.
- Develop and distribute information on basic home diagnostic procedures to help people decide when it is appropriate to get medical help.
- Analyze patient's patterns of office visits and assign patients making inappropriate use of physicians' services to the general practitioner of their choice.
- Remove professionally imposed limits on pricing and advertising for those health care services which people must purchase at their own expense.
- Remove legislation and regulations which place otherwise anti-competitive activities beyond the reach of the federal Competition Act.

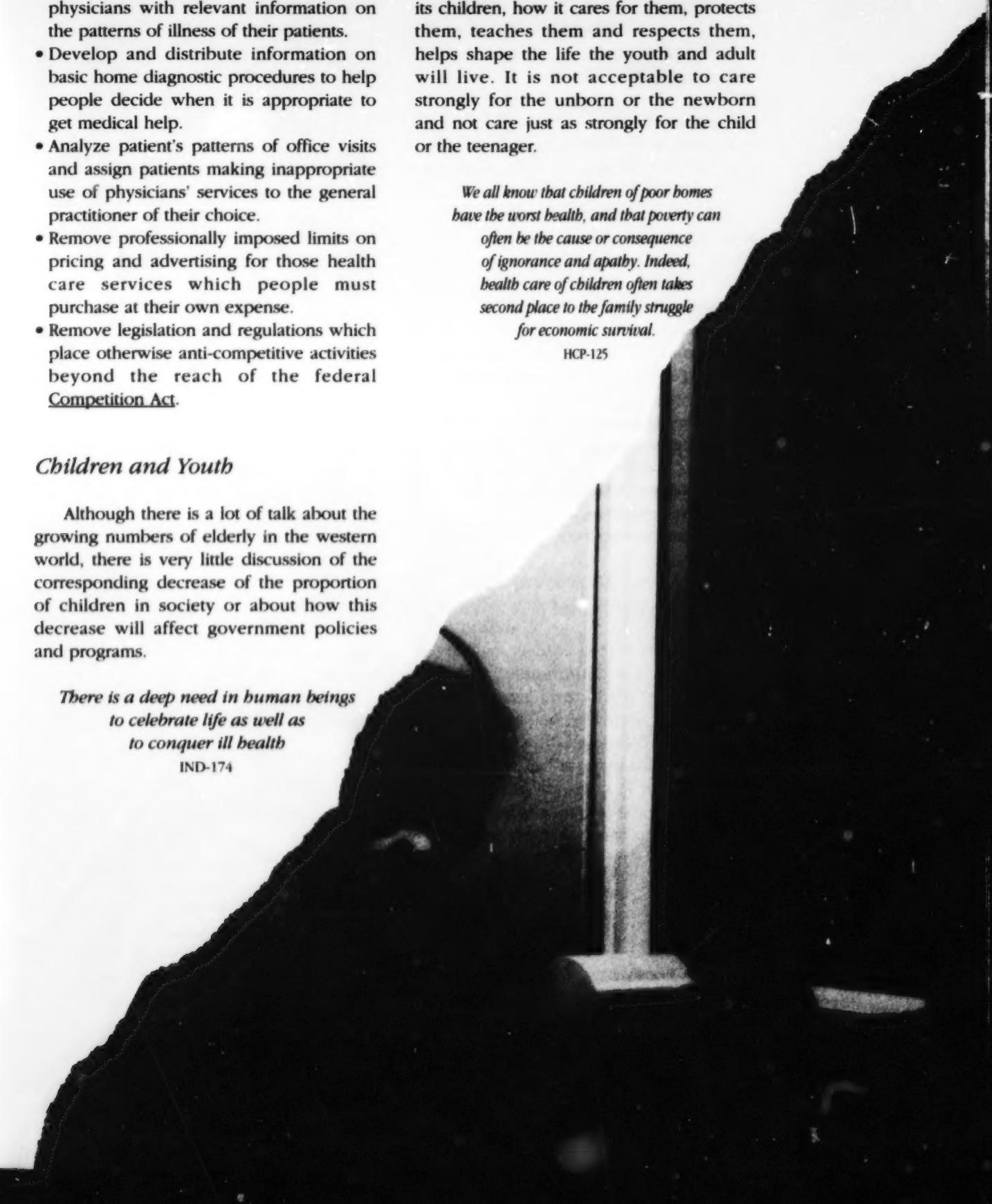
Children and Youth

Although there is a lot of talk about the growing numbers of elderly in the western world, there is very little discussion of the corresponding decrease of the proportion of children in society or about how this decrease will affect government policies and programs.

There is a deep need in human beings to celebrate life as well as to conquer ill health
IND-174

Life is a continuum. How society views its children, how it cares for them, protects them, teaches them and respects them, helps shape the life the youth and adult will live. It is not acceptable to care strongly for the unborn or the newborn and not care just as strongly for the child or the teenager.

We all know that children of poor homes have the worst health, and that poverty can often be the cause or consequence of ignorance and apathy. Indeed, health care of children often takes second place to the family struggle for economic survival.
HCP-125



... think broadly about BC, 50 or 100 years from now, because the health care system that we build today will serve our children's children tomorrow.
IND-331

Strategies for Change

- Develop standards for child care programs which are based on increasing the social, psychological and physical functioning of children.
- Increase welfare rates for families with children.
- Establish targets and long-term strategies to reduce child abuse, the effects of child abuse and family violence.
- Reduce violence on television and encourage parents to control a child's choice of programs.
- Develop the capacity to track prenatal care and evaluate quality of care.
- Ensure that all children have an adult responsible for them by appointing advocates for infants of parents who are minors.
- Provide information and counselling on the long-term consequences for children, families and society of severely disabling conditions, such as anencephaly. This should include providing abortions to those people who choose that option.
- Develop prenatal education packages and video tapes in the major language groups in the province.
- Expand prenatal and outreach programs to more communities.
- Develop protocols for the referral of high-risk mothers to prenatal outreach programs and monitor physician compliance with the protocols.
- Locate prenatal projects in communities where there is a high incidence of low birth weight children.
- Develop travelling rehabilitation teams for underserviced rural areas.
- Adopt the World Health Organization's code on the marketing of breast milk substitutes.
- Implement an injury surveillance system in schools that will include school yards and the areas immediately around the school.
- Develop a province-wide emergency unit injury reporting system.
- Implement a province-wide school lunch program and ensure that schools have programs on nutrition and physical health.
- Amend the Municipal Act to require fluoridation of all community water supplies.
- Fund prevention programs for improving dental health in children.
- Fund youth health clinics throughout the province and develop a screening program for chlamydia infection in high-risk young women.

Native Health

The origins of the great Coastal and River Valley cultures of the Native people of British Columbia go back thousands of years. A dwelling site in the Lower Fraser Valley, recently dated at over 5,000 years old, is the oldest known structure in the Pacific Northwest. Yet, today, the life of many of these first British Columbians can be described as "third world" in its dimension.

Although we recognize that many of the health problems found in the Native community are bound up with social, economic and political concerns, we do not have the time or mandate to deal with these issues. That does not mean, however, that steps cannot be taken right now to improve the health status of Natives. The issue of human health is more important than arcane constitutional arguments.

The information available on Native health and the conditions which affect it is not adequate for planning and policy purposes. However, after years of being studied, Native populations are reluctant to participate in social surveys in which they have no control over the information gathered or how it is used. Programs aimed at helping Natives deal with alcoholism, drug abuse, sexual and physical abuse and the spread of HIV/AIDS in their communities must be under the control of the Native communities.

Strategies for Change

- Increase the number of Native children who complete high school.
- Support job training programs developed by Native communities.
- Consult with Native communities to develop an information system to measure the health determinants and health status of Native people.
- Develop and support drug and alcohol programs including needle exchanges for Native youth, women and IV drug users.
- Make the office of the Chief Native Adviser for Native Health into a separate branch within the Ministry of Health with its own assistant deputy minister.
- Place the responsibility for planning and implementing housing, education and employment programs in the hands of Native people.
- Support Native-controlled health care services, including services to urban Natives.
- Ensure that, until such time as there are agreements between Native groups and the federal government, the federal government meets its constitutional responsibility to all Native people, status and non-status, both on and off reserve.
- Increase the number of community health representatives and develop a similar program for urban Native populations.
- Support training opportunities for Native people as non-professional health care workers.
- Designate positions and provide support for Native people to enter the health care professions.
- Develop mental health programs for Native communities which focus on sexual abuse counselling for the victim, the offender and the family.
- Provide cross cultural staff training and hire Native staff in provincial health units.
- Establish the reduction of sexually transmitted diseases among Natives as a government priority, without regard for jurisdictional disputes.
- Establish a Native AIDS centre. This centre should support education and prevention programs, distribute material and operate an AIDS 1-800 line.

Unless we settle the lands claim issues, address poverty, social and cultural and environmental problems, cut the strings of government dependency and allow for true equality, you'll simply continue to provide expensive bandaid answers.

PRO-129

Immigration and Multicultuaral Health

Between 1975 and 1990, 1,908,415 people immigrated to Canada. Of this number, 279,031 people (14.62%) took up residence in BC, the majority of these in the lower mainland. Between 1990 and 1995, a further 1,170,000 are expected to arrive in Canada and all indications are that approximately 160,000 will settle here. Twenty-two percent of British Columbians are now foreign born, compared to a national average of 15 percent. Unless fertility rates or migration trends change noticeably in BC, the proportion of foreign born British Columbians will increase.

We have seen people who have died of breast cancer or uterine cancer because their access to the health care system was compromised by linguistic and cultural isolation.

SOC-075

New Canadians are a diverse group. They speak over 50 different languages and a large number of them have no understanding of English or French. This language barrier, combined with cultural practices unfamiliar to health care workers and a lack of knowledge of the health care services by new Canadians, greatly complicates meeting the needs of these people. Time spent in hospitals and continuing care facilities is a particularly difficult and isolating experience for them.

Strategies for Change

- Encourage the development of continuing care services and facilities for specific cultural and linguistic groups.
- Create non-professional community health aide positions.
- Develop health education information for different cultural and linguistic groups and distribute it through newspapers, home videos television and radio channels.
- Develop training programs to make health care workers more sensitive to cultural differences.
- Urge the federal government to assume all medical and social costs for refugees for their first five years in Canada. Implement mandatory standards for immunization prior to entry and require all people seeking landed immigrant status to present evidence that they have received a complete set of immunizations.
- Refuse entry as an immigrant to any person who tests positive for an infectious, incurable disease.

Services to People with Disabilities

Wide variations in the range, quality and organization of support services in BC create barriers and limit the ability of people with disabilities to live independently. The greatest barriers are often government ministries themselves, which sometimes seem intent on frustrating access to resources such as equipment, names and contact numbers for agencies, and knowledge about the services they supply.

Strategies for Change

- Develop, maintain and publish a *Resource Registry*. The registry should include a list of services and how to get them, the equipment available and its location, the names and numbers of all of the agencies providing services and equipment, and information on housing. The Ministry of Health should immediately release *The Report on the Provision of Medical Equipment and Supplies to the Chronically Ill and Disabled Population in BC*, and its recommendations, and work with other ministries to establish consistent policies for supplying equipment.
- Develop and maintain a *Registry of Individuals with Disabilities* to help monitor the changing needs of the population. This registry should be linked to the BC Housing Management Corporation's registry of people requiring modified housing.
- Appoint Children's Hospital, Queen Alexandra Hospital, Sunny Hill Hospital and the BC Rehabilitation Society G.F. Strong Centre as the agencies jointly responsible for setting provincial standards and providing consultation to the regions.
- Evaluate the eligibility criteria for the *At Home Program* and *In School Protocol* to make sure that the focus of the programs is appropriate. The results of this evaluation should be made public.
- Train an appropriate number of special care assistants and upgrade licensed practical and registered nurses in working with technology-dependent children and their families.
- Develop a care plan for each person with a disability and review the plan annually.
- Ensure that vocational rehabilitation consultants take part in determining the employability of a person with a disability. The decision should be reviewed every year for the first two years.
- Make more flexible use of *GAIN for the Handicapped*. Remove its current disincentives to work.
- Ensure that all new housing built with public funds be wheelchair adaptable.
- Establish new legislation to protect people with mental disabilities.
- Evaluate criteria for establishing care levels to ensure that they support independent living.

Disability
is somewhat
of an equal
opportunity situation.
At any given time
in our life
any one of us
could join
this elite group.
ROUND TABLE
DISCUSSION

...you've got
a young person with
a very severe
head injury,
who's going
to be a care problem
for the rest of their lives, and heaven knows,
they may live sixty
or eighty years.
HCP-020

Substance Abuse

Alcohol consumption and the use of both licit and illicit drugs is declining in Canada; however, a large number of Canadians continue to drink heavily and to misuse drugs.

Surveys by Alcohol and Drug Programs (ADP) show that, consistent with national trends, alcohol and drug use is declining among BC youth. But this positive news is tempered by results that show our youth experimenting with alcohol and other drugs at increasingly earlier ages. The ADP survey showed that the rate of alcohol use by Grade 12s in BC is greater than the rates of adult use in a number of other provinces. More than 20 percent of children aged 12-15 begin smoking cigarettes regularly.

The Nak'azdli reserve has 1,058 registered members on April 1, 1990, six hundred of whom suffer from the effects of alcoholism in one form or another.
NAT-017

The inappropriate use of medications can cause illness, hospitalization, or even death. Yet approximately 40 percent of British Columbians over 60 years of age use non-prescription drugs every day, a trend which generally increases with age. Our seniors, who comprise 12 percent of the BC population, currently consume 40 percent of the prescription drugs. Alcohol abuse, which is difficult to recognize in the elderly, could be as high as 10-15 percent.

Substance abuse is also a major challenge facing Canada's Native peoples. The involvement of Natives in the design and development of alcohol treatment programs has been successful and is fundamental to the success of future programs.

Collecting information on the cost of substance abuse has not been a priority for the government and the available data are limited and confusing. Estimates of the cost to British Columbians of substance abuse range from $2 billion to $5 billion a year.

Strategies for Change

- Establish the *BC Alcohol and Drug Commission* as an autonomous commission.
- Prohibit the purchase of alcohol with public money.
- Reduce the number of liquor outlets, hours of operation and days of sale.
- Prohibit the promotion of alcoholic products.
- Enforce laws prohibiting the sale of alcohol to minors or intoxicated people.
- Extend the current ban on advertising spirits in the broadcast media to include beer and wine.
- Publish health warnings on liquor labels with particular attention being paid to the effects of alcohol on pregnancy.
- Index taxes on alcohol.
- Increase countermeasures to fight drinking/driving including graduated licensing, passenger and speed restrictions, and zero blood alcohol tolerance levels for novice drivers.
- Establish a system of assessment, referral and treatment for impaired drivers.
- License the sale of tobacco products and revoke the license of any vendor who sells tobacco to a minor.
- Prohibit pharmacies from selling tobacco.
- Prohibit tobacco vending machines.
- Prohibit the sale of cigarette packages containing less than 20 cigarettes.
- Impose a tax on the promotion of tobacco products.
- Prohibit the use of tobacco by adults and children on all elementary and secondary school property.
- Ban the advertising of tobacco products, even if it means resorting to the "notwithstanding" clause of the Canadian Charter of Rights and Freedoms.

Mental Health

The submissions to the commission make it painfully clear. The medical care system is failing the mentally ill in BC. "Downsizing" Riverview Hospital has not been well organized, adequate facilities have not been provided in the province's communities, hospital care is fragmented and there is a lack of psychiatrists and clinical psychologists.

That's what most of those people on the street are. They're ill and nobody wants to look after them.

From: Transcripts,
The Royal Commission on Health Care and Costs

Strategies for Change

- Publish a five-year plan detailing the Ministry of Health's policy directions for the Mental Health Services Division including strategies to encourage community-based planning, methods for evaluating the mental health care system and its components, and clearly stating the purpose and use of transitional money.
- Develop provincial, regional and local multi-year plans for the promotion of mental health and the prevention and treatment of mental illness. The highest priority for these plans must be for children and youth.
- Develop coordinated policies, procedures and regulations among ministries.
- Define the mandate of general and psychiatric hospitals.
- Replace the board of Riverview Hospital with one composed of members of the public.
- Establish explicit standards for care.
- Reward institutions providing high quality care.
- Require psychiatrists in private practice to provide hospital services, as deemed necessary by the regional general manager.
- Pay psychiatrists who provide inpatient and emergency services a fee equivalent to those who work in private practice.
- Conduct a value for money audit of the Mental Health Services Division.
- Evaluate the effectiveness of hospital and community-based mental health programs.
- Develop a coherent and managed system of care that provides continuity of care and active case management.
- Make residential housing, day programs and respite care priorities.
- Review the decision to close Woodlands. The people currently at Woodlands should be independently assessed to determine where they will receive the best treatment. Deinstitutionalization is not the answer to every problem.
- Stop using Colony Farm. The buildings are not fit to house people.
- Develop an information program to improve the public's understanding of mental illness and its acceptance of the mentally ill.
- Provide dedicated pre-school support services in each health unit in the province.
- Plan and design the mental health system upon the philosophy of the least restrictive and lowest level of intervention possible consistent with high quality care.
- Review the case of all people held under involuntary admissions.
- Publish annually the number of voluntary and involuntary admissions in the province.

There's a 90 million dollar budget (for Riverview Hospital). I'm not saying it's spent wrong, but I don't know how it's being spent at all. I don't know how I'm spending the money.

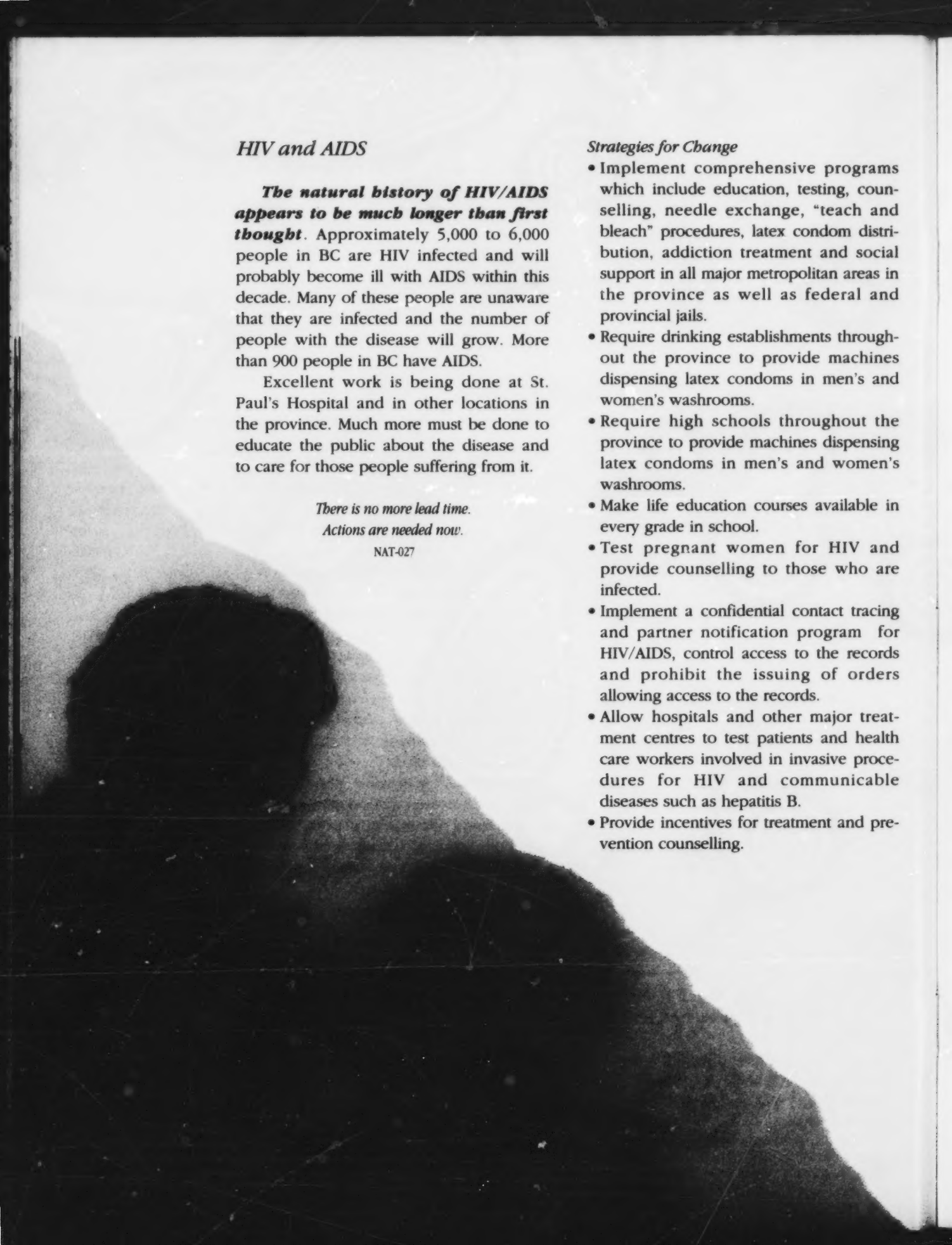
ROUND TABLE DISCUSSION

HIV and AIDS

The natural history of HIV/AIDS appears to be much longer than first thought. Approximately 5,000 to 6,000 people in BC are HIV infected and will probably become ill with AIDS within this decade. Many of these people are unaware that they are infected and the number of people with the disease will grow. More than 900 people in BC have AIDS.

Excellent work is being done at St. Paul's Hospital and in other locations in the province. Much more must be done to educate the public about the disease and to care for those people suffering from it.

There is no more lead time.
Actions are needed now.
NAT-027



Strategies for Change

- Implement comprehensive programs which include education, testing, counselling, needle exchange, "teach and bleach" procedures, latex condom distribution, addiction treatment and social support in all major metropolitan areas in the province as well as federal and provincial jails.
- Require drinking establishments throughout the province to provide machines dispensing latex condoms in men's and women's washrooms.
- Require high schools throughout the province to provide machines dispensing latex condoms in men's and women's washrooms.
- Make life education courses available in every grade in school.
- Test pregnant women for HIV and provide counselling to those who are infected.
- Implement a confidential contact tracing and partner notification program for HIV/AIDS, control access to the records and prohibit the issuing of orders allowing access to the records.
- Allow hospitals and other major treatment centres to test patients and health care workers involved in invasive procedures for HIV and communicable diseases such as hepatitis B.
- Provide incentives for treatment and prevention counselling.

- Fund continuing education, clinical fellowships in HIV/AIDS care for physicians and support programs, including sheltered housing and group homes for specific populations.
- Develop screening programs with as broad an application as possible to determine and monitor the spread of HIV.

Diagnostic Imaging Services

Policies respecting the purchase, placement, use and funding of computed tomography (CT) scanners, magnetic resonance imagers (MRI) and x-ray machines are questioned a number of times in submissions to the commission. Ultimately, the issues raised by these diagnostic imaging services are no different from those raised by any other service or procedure in the health care system: ***tax dollars must be spent on providing the best quality care in the most cost-efficient manner possible***.

Strategies for Change

- Retain the responsibility for the funding and placement of tertiary diagnostic imaging services within the Ministry of Health and make public the information on which the ministry's decisions are based.
- Fund the capital and operating costs of standard diagnostic imaging equipment out of regional funding envelopes administered by the regional general manager in consultation with the community.
- Evaluate newly developed equipment at a single provincial centre.
- Remove the requirement that a radiologist report on every x-ray for those x-rays in which the radiologist's report does not have the potential to change the treatment of the patient.
- Develop guidelines in consultation with radiologists and local advisory boards for the use of diagnostic imaging services.

Laboratory Services

Clinical laboratory services have grown significantly in recent years. But there is currently no regulatory framework for monitoring, evaluating or modifying their use.

One hospital may see the laboratory as a cost centre, one may see it as a service centre, and one may see it as a profit centre.
PRO-021

The ownership of laboratories is poorly recorded, raising questions about conflict of interest. Hospital inpatient work is poorly recorded. Data collection is poorly organized. And there is no clear evidence that by ordering more tests, physicians are, in fact, learning more about their patients, and thereby providing better care.

After adjusting for general inflation there has been some, but relatively little, increase in the costs of each test, and the primary factor underlying the growth in both inpatient and outpatient laboratory costs has been the increasing volume of tests ordered and performed. The most extreme example is high density lipoprotein testing – cholesterol screening – which increased by *1,326* percent between 1979/80 and 1988/89 despite clear recommendations from the Canadian Task Force on Periodic Health Examination that only high-risk individuals should be tested as there is little value in mass screening of the non-high-risk population. The fee increase over this period was 51.1 percent, similar to the general rate of inflation.

Payments to laboratories are made up of fees charged for each individual test. These fees are part of the general fee schedule negotiated between the BC Medical Association and the Ministry of Health. Fairness to all physicians and the taxpayer demands that this be reviewed.

It's financial idiocy
to spend $3 million plus to open an MRI facility,
and then tell you
you're going to run it
four days a week
on one shift.
SOC-059

Strategies for Change

- Reduce the potential for conflict of interest by establishing an ethical standard that physicians may not order tests from a laboratory in which they have an interest. The Medical Services plan should not pay laboratories for tests ordered by a physician who receives any financial benefit from the tests.
- Remove the requirement that a laboratory must be owned and managed by a physician.
- Remove payments for laboratory services from the fee-for-service schedule.
- Develop and monitor protocols for the appropriate ordering of tests and do not pay for tests which do not meet the protocols.
- Contract out large volume routine testing on a competitive basis.

Prescription Drugs

Three basic principles apply to the use of prescription drugs. First, the potential for an increase in the health status of the person must outweigh the risk of harm. Second, drug therapy should be provided to the residents of BC at the lowest cost necessary to meet their needs. Third, no resident should be denied access to drug therapy because of an inability to afford treatment.

It is apparent from the submissions and our research that these principles are not being met.

There are some low income families who do not benefit from the method of reimbursement now in place for prescription drugs, because they cannot afford to pay for the drugs in the first place.
UNI-027

Strategies for Change

- Expand the current system for reviewing the prescribing patterns of physicians to include a larger number of target drugs.
- Develop an electronic network linking physicians, pharmacies and health care facilities so that physicians and pharmacists have access to the diagnostic, medication and allergy status of patients, potential drug interactions, the guidelines of the Drug Usage Review program, and the Drug and Poison Information Centre.

The commission recognizes that confidentiality and privacy are significant concerns and must be maintained to the extent possible.

- Emphasize the pharmacological needs of the elderly in testing and continuing education.
- Ensure that the hospital pharmacist plays an active clinical role in ward rounds.
- Extend the drug approval process to include post-marketing surveillance including evaluation of the effects on populations — such as pregnant women, the elderly, children and people with multiple illnesses — not covered in pre-marketing trials.
- Reduce the amount of unused and misused medication.
- Institute a system whereby patients pay only their share of the Pharmacare deductible and change the deductible portion under Plan E from a flat $2,000 to 5 percent of a family's income.
- Review the effectiveness of the federal Patented Medicine Prices Review Board and make the review public.
- Implement a system of mandatory drug price and product selection based on generic equivalents for brand name drugs.
- Prohibit the filling of prescriptions for drugs available on the open shelf.
- Limit the number of products that must be sold within 25 feet of a pharmacist to those containing controlled substances.
- Ensure that pharmacists are directly involved in dispensing drug products which require their supervision.

Hospitals

Hospitals currently consume almost half of the Ministry of Health's $5.4 billion budget. The appropriateness of hospital use and the proper scope and scale of the hospital sector are, therefore, major issues for health care in BC. If the focus of health care is going to change from institutions to the community, and if there are going to be alternative programs that offer care *closer to home*, then there must be changes in the operation and funding of the acute care sector. This will mean educating the public as to how hospitals are funded, what they are funded to do, and what they should not be funded to do.

According to an analysis carried out for the commission, British Columbians could have saved approximately 680,000 acute and rehabilitation inpatient days out of a total of 3.2 million days in fiscal year 1989/90. This is due to unnecessarily extended lengths of stay for short and long-term stay patients, and inappropriate admissions and forms of care. Six hundred and eighty thousand days of care represent the capacity of over 2,300 beds run at 80 percent occupancy. Occupants of acute care beds who had been assessed as eligible for long term care would account for another 250,000 days.

This represents an enormous pool of funds that should be redirected toward other sectors of health care. The number of health care jobs will not shrink; the population is growing. But many of these jobs should move, ***with the funds***, outside hospital walls into expanded outpatient and community health services, free-standing, non-hospital based facilities and multi-level care nursing homes.

Strategies for Change

- Increase home support programs in order to shift both resources and patients out of institutional settings.
- Allocate funding so that funds follow people wherever they go.
- Develop and enforce protocols defining appropriate lengths of stay.
- Support free-standing clinics or other institutions which provide some services equivalent to those of a hospital.
- Establish common accounting guidelines for comparing the costs of care provided in different institutions.
- Inform the public about the appropriate use of hospitals, practice guidelines, the present patterns of hospital use and the policy of moving people and resources out of hospitals.
- Define the mandate for each hospital and free-standing clinic in each region of the province, the services they will provide and the population they will serve. Institutions should not be able to change these mandates without public consultation and the Ministry of Health should reduce funding to those hospitals which do not fulfil their mandates.

A true health care system would concentrate on reducing our need for doctors and nurses in acute care hospitals. Obviously there will always be a need but our objective should be the reduction of that need.
MUN-020

There has to be the political will to really close beds. If you have shorter lengths of hospital stay, early discharge, fewer problems, you've actually got to have the will to either close the bed or defer building new hospital beds and staffing them.
HCP-004

- Deem all adult residents of the community served by a hospital to be members of the society.
- Ensure that no person who works in, works for, holds privileges at, or has business dealings with a hospital shall be eligible for election or appointment to that hospital's board of trustees as a voting member.

Home Care

Care provided in the home, or on an outpatient basis, is preferable to institutional care. Whether home care can be a viable option to institutional care depends largely on the resources that support it. We think that the resources will be found in the reduction of the acute care sector. But only if this reduction is accompanied by the appropriate placement of long-term stay patients in less expensive continuing care facilities or back in the community, and if physician services do not increase.

Strategies for Change

- Involve the informal caregiver in care planning and increase the power of the patient and the informal caregiver to participate in decisions about the type of home support provided and who will provide it.
- Increase support for and flexibility in respite care.
- Establish standard guidelines for discharge planning for every person admitted to hospital.
- Develop geriatric and psychogeriatric assessment programs in the community and establish mobile teams to visit communities which cannot support their own programs.
- Remove the barriers which limit the ability of health care workers to fulfil a variety of positions.
- Pay family members as home care workers in appropriate situations.
- Support adult day care centres and make institutional services available to people in the community to help those people remain in the community.
- Establish the procedure for an expeditious appeal to an independent authority from the decision of a case manager or assessor.
- Increase health care worker sensitivity to cultural differences.

It would be more cost effective for us to institutionalize my husband. That would solve all the monetary and physical problems we encounter daily. We choose to have him at home for as long as possible despite these hardships, but it is certainly not through the encouragement of the health care system of BC.
IND-318

Long Term Care Facilities

Three basic principles should guide the decisions which affect long term care. First, long term care facilities are people's homes. The people who live in them are residents, not patients, and the management, the physical layout and the design of care facilities must take this fact into account.

Second, it is better for long term care residents to live in a less than perfect facility ***within their own community***, than to be placed in a facility which meets all of the province's health, safety and building requirements, but is separated from family and friends.

Third, ***an insufficient number of long term care beds will eventually raise costs in the acute care sector and other areas of health care***.

Strategies for Change

- Move the responsibility for extended care units from the hospital services division to the continuing care division so that all long term care services are the responsibility of one division.
- Separate extended care units, physically and financially, from hospitals, except in smaller communities where the units should receive their own budgets.
- Develop specific facilities for young residents and cultural groups.
- Modify intermediate and extended care facilities to multi-level standards to provide a wider range of care in one facility.
- Provide effective physiotherapy in intermediate care facilities.
- Improve the level of training in geriatrics and psychogeriatrics for long term care personnel.
- Encourage in-service training and exchanges.
- Establish special care units for seriously demented residents.
- Ensure that private long term care facilities are subject to the same quality control as public facilities.
- Encourage supportive housing units.

Palliative Care

The commission has been impressed by the deep concern throughout the province that the last days of someone's life be as fulfilling and pain-free as possible. Although British Columbians can be proud of the current programs and the people who work in palliative care, particularly the volunteers, more can be done to help the dying.

Strategies for Change

- Develop and distribute guidelines and a training package for providing palliative care.
- Develop palliative care programs in each community, coordinated, if possible, by the volunteer sector working in partnership with local hospital and home care programs. These programs should include uniform guidelines, assured access to home nursing and home support, immediate access to community hospital beds, transfer of a portion of existing hospital and home care program budgets and the selection of palliative care teams from existing care providers and volunteers.
- Provide the drugs, supplies, equipment and services necessary for in-home palliative care at no cost to the patient.

We believe that the transfer of our seniors to facilities 100 or more miles from their elderly spouses, and their whole community support system, is really deplorable.

HOS-193

You matter because you are you. You matter to the last moment of your life and we will do all we can, not only to help you die peacefully, but also to live until you die.
Dame Cicely Saunders (founder of the hospice movement)

Dying with Dignity

We cannot expect, even with the best health care, to live forever, and any system that we have is going to have to allow us to live with dignity as well as to die with dignity.

From: Transcripts,
The Royal Commission on Health Care and Costs

Strategies for Change

- Request that the Criminal Code be amended so that a competent adult patient, or the duly appointed proxy of a patient who is not competent, has the absolute right to refuse medical treatment or demand that it cease.
- Request that the Criminal Code be amended so that if a terminally ill patient's suffering cannot be otherwise relieved, a physician may prescribe, and a health care worker may administer, any therapeutically necessary pain relief medication to that patient in a dose which may be fatal.
- Request that the Criminal Code be amended so that section 241 (b) does not apply where the person who commits or attempts to commit suicide is terminally ill, and the health care worker who helps that person commit or attempt to commit suicide does so in accordance with the ethical standards of his or her profession.
- Enact legislation and request that the Criminal Code be amended so that physicians may withdraw or withhold treatment if: a patient is terminally ill or exists in a persistent vegetative state, no longer enjoy any quality of life and cannot give or withhold consent; and, the physician is of the opinion that the treatment is therapeutically useless.

Health Care Personnel

The province's most significant health care resource is people.

Dr. Richard Foulkes recognized this in his 1973 report, ***Health Security for British Columbians*** and recommended that the province promptly undertake a study of the health care personnel needs of BC. He also recommended that the Ministry of Health and the province's educational institutions stop creating new categories of health care workers until the personnel study was complete.

This did not happen and 18 years later this commission is recommending the same thing. Find out what the province needs, make the findings public and fund educational institutions to train the health care personnel that the province needs.

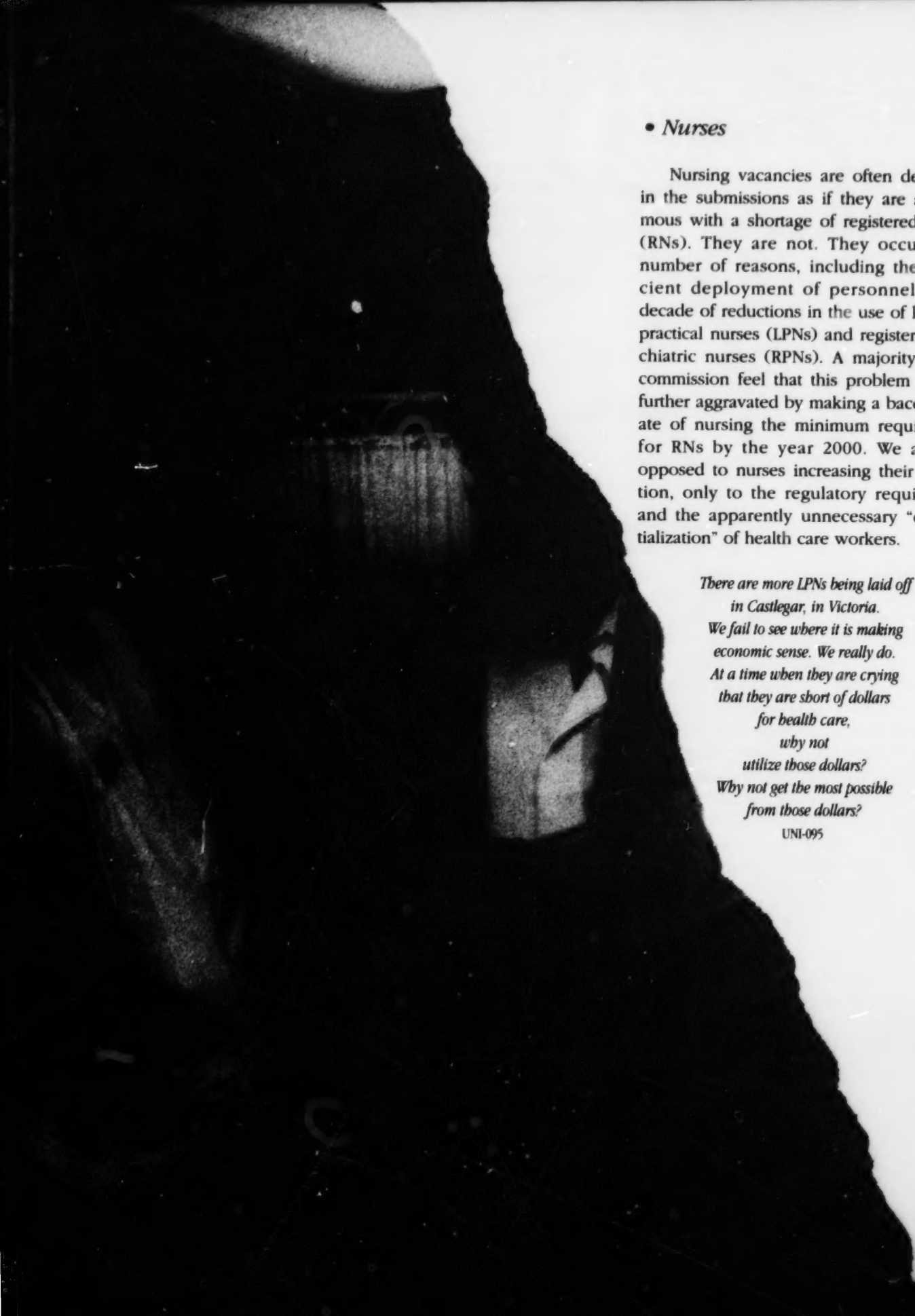
• *Physicians*

The supply of physicians, their distribution and their patterns of practice affect the quality, financing and organization of health care. There are 50 percent more active physicians per capita in BC than there were in 1970 and fewer patients per physician in BC in 1990 than in any other province in Canada. Yet, there are shortages of physicians in rural and remote areas of the province, and in some specialties.

Payments to physicians through the Medical Services Plan account for approximately one-quarter of the Ministry of Health's budget, a budget made up, of course, of taxpayers dollars. But like many parts of the health care system, there is no public oversight of the negotiations between the ministry and the BC Medical Association.

Strategies for Change

- Develop a provincial health care personnel plan.
- Ensure that post-graduate training is consistent with the provincial health care personnel plan.
- Limit positions for graduates of foreign medical schools to those necessary to meet the provincial need, taking into account the special needs of immigrant populations.
- Encourage Canadian graduates to train in fields in which there are shortages.
- Create an office within the Ministry of Health to fill difficult-to-fill positions.
- State clearly that immigrant physicians do not have a right to practice medicine in BC.
- Require visa trainees to agree not to stay in Canada when they complete their training.
- Develop a program to limit the number of physicians practising in BC.
- Promote salaried positions and contractual arrangements as an option to fee-for-service.
- Limit expenditures for physician services by imposing an annual global cap on the total billings by physician. This should include the use of regional caps and caps on the amount paid for general practitioners and specialists.
- Establish a permanent, independent board to monitor and publish annual reports on the structure of the fee-for-service schedule, the relative value of various items in the schedule and the effect of the schedule on health care in BC.
- Improve fringe benefits for physicians in rural and remote areas.
- Provide professional and technical support as well as temporary replacements, subsidized travel, isolation allowances and continuing education for physicians in rural and remote areas.
- Encourage physicians to be involved in managing the hospital system.
- Require all physicians to remit dues to the BC Medical Association and be bound by its collective agreement (Rand Formula).



• *Nurses*

Nursing vacancies are often described in the submissions as if they are synonymous with a shortage of registered nurses (RNs). They are not. They occur for a number of reasons, including the inefficient deployment of personnel and a decade of reductions in the use of licensed practical nurses (LPNs) and registered psychiatric nurses (RPNs). A majority of the commission feel that this problem will be further aggravated by making a baccalaureate of nursing the minimum requirement for RNs by the year 2000. We are not opposed to nurses increasing their education, only to the regulatory requirement and the apparently unnecessary "credentialization" of health care workers.

There are more LPNs being laid off
in Castlegar, in Victoria.
We fail to see where it is making
economic sense. We really do.
At a time when they are crying
that they are short of dollars
for health care,
why not
utilize those dollars?
Why not get the most possible
from those dollars?
UNI-095

The submissions also clearly state that nurses feel undervalued. This should not be interpreted as a purely monetary problem; nurses have fared better than most workers in BC in terms of increases in salary over the last 10 years. Instead, the structure of hospital culture needs to be improved, nurses need to be involved in clinical and administrative decisions and there must be greater scope in the nursing career ladder.

Strategies for Change

- Develop data base and monitoring systems to help achieve a more appropriate mix of full-time, part-time and casual nurses.
- Limit the use of non-unit-specific casual or agency recruited float staff.
- Provide appropriate orientation for new nurses.
- Require the use of LPNs and RPNs in institutions where their employment is consistent with efficiency and quality care.
- Increase nurse participation in clinical and administrative decisions.
- Prohibit head nurses and other nurses in management roles from belonging to nursing bargaining units.
- Increase the differentials between first year and experienced RNs, LPNs and RPNs.
- Reject the baccalaureate as the minimum requirement for RNs.
- Develop a continuum of education from nurses' aide through LPN, diploma RN and baccalaureate RN. Professional associations should not be allowed to interfere with this continuum.
- Promote cross-faculty teaching and a transferable credit system in training institutions.

The demand for increasingly academic qualifications is a demand created by the professionals.
PRO-025

• *Allied Health Care Workers*

Allied health care workers are a major part of health care. It is impossible to build an integrated system without them and the arbitrary limits that have been placed upon them must be removed in order to provide the best care possible to the greatest number of people possible.

Strategies for Change

- Identify the need for allied health care workers in the provincial health care personnel plan.
- Increase the limit of 12 visits per year to a physiotherapist.
- Allow rehabilitation therapists in private practice to provide services to patients in the community and, where applicable, in institutions.
- Expand the public sector role of licensed psychologists.
- Train rehabilitation aides to work with rehabilitation therapists, or, where appropriate, on their own.
- Permit chiropractors to treat their private patients in institutions unless the attending physician determines that the treatment would be detrimental, or, in acute care institutions, the institution refuses permission.
- Require physicians and institutions to provide copies of x-rays to a patient at cost.
- Decrease the number of visits to a chiropractor that the Medical Services Plan covers for people under 65 from 12 to ten and from 15 to 12 for those over 65.
- Allot each chiropractor one-fifth of the total number of visits billed in the previous year to be used for patients who need more than ten or 12 visits.

• *Midwives*

Midwifery is a widely accepted practice throughout the world. Recently, other provinces in Canada have moved to legitimize midwifery and we believe that it is time BC did the same thing. It is the view of this commission that, wherever possible, safe and practicable, people have the right to choose who will care for them.

Strategies for Change

- Grant nurse-midwives a scope of practice under the Nurses (Registered) Act and amend the Medical Practitioners Act.
- Allow midwives to deliver babies in hospitals.
- Establish a college of midwifery pursuant to the Health Professions Act.
- Permit nurses to belong to both the Registered Nurses' Association of BC and a college of midwifery.
- Monitor the costs associated with midwifery to ensure that it is a substitute for physician care, and not an add-on to the present system.

Regardless of the risk factors,
a midwife based system
is an excellent way
of coming up
with good outcomes,
superb outcomes.
HCP-247

Labour Relations

A number of factors influence labour relations in the health care field: health care enjoys an almost sacred status in the public's opinion; collective agreements exert very little pressure to perform efficiently; there is a predominance of women in the system; and the present Industrial Relations Council is a failure as a labour tribunal. Designating the entire health care industry an essential service is a theme in some submissions. But, the commission believes that collective bargaining is an important characteristic of labour relations.

Strategies for Change

- Create a new labour relations tribunal that has the trust and respect of all parties.
- Increase support for women in the health care labour force.
- Resolve disputes during the life of the collective agreement.
- Enact pay equity legislation.
- Designate essential services during the life of the contract.
- Reduce the number of bargaining agents for both employers and unions.
- Reject binding arbitration as a substitute for collective bargaining.

Many health care occupations
remain underpaid
for the simple reason that
they are largely
performed
by women.
UNI-011

The Governance of the Health Care Professions

Sixteen different acts govern the health care professions. These acts lack consistency, yet all must have the same, single purpose: to protect the public from preventable harm.

These acts have a powerful effect on health care services. In many cases, they have become the fortresses of professionalism, devoid of their original intent. Often, the people responsible for overseeing the colleges and associations set up by these acts demonstrate a profound misunderstanding of the distinction between protecting the public and protecting their own interests.

If the health care system in BC is going to change, then the acts governing the health care professions must change as well.

Strategies for Change

- Repeal and revise the new Health Professions Act so that it becomes an umbrella act, regulating all of BC's health care professions.
- Retain provisions unique to each profession under small satellite acts.
- Prohibit any change to the Health Professions Act, or the satellite acts, without prior review and approval by the Health Professions Council.
- Ensure that exclusive scopes of practice protect the public from potentially harmful acts by adopting the approach recently taken by Ontario.
- Involve all health care professions and, more importantly, the public in defining scopes of practice.
- Amend the Society Act so that the Health Professions Council must approve an occupational title or abbreviation for any health care group. This would include revoking all titles granted under the Act that had not been approved by the Health Professions Council within two years of the passing of the revised Health Professions Act.
- Limit the use of the words "registered", "licensed" and "certified" by health care workers.
- Allow health care workers to belong to more than one college.
- Remove restrictions which limit the ability of members of different colleges to work together.
- Separate the function of membership promotion and the function of protecting the public. If there are not sufficient members in a profession to have a separate college and membership promotion association, then a college should not be established.

In any other realm of the free enterprise system, the current control by the profession of medicine on utilization of dollars, entry into the health care system, and control of the referral system, would be considered a monopoly

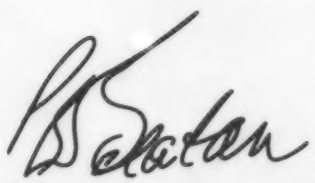
HCP-188

Toward Tomorrow

There are very few people as fortunate in their history and institutions as British Columbians. There are very few people that share our general level of prosperity, freedom, or good health. Vast geographical distances separate communities, and yet there is a sense of being British Columbians, of being the inheritors of a magnificent common wealth.

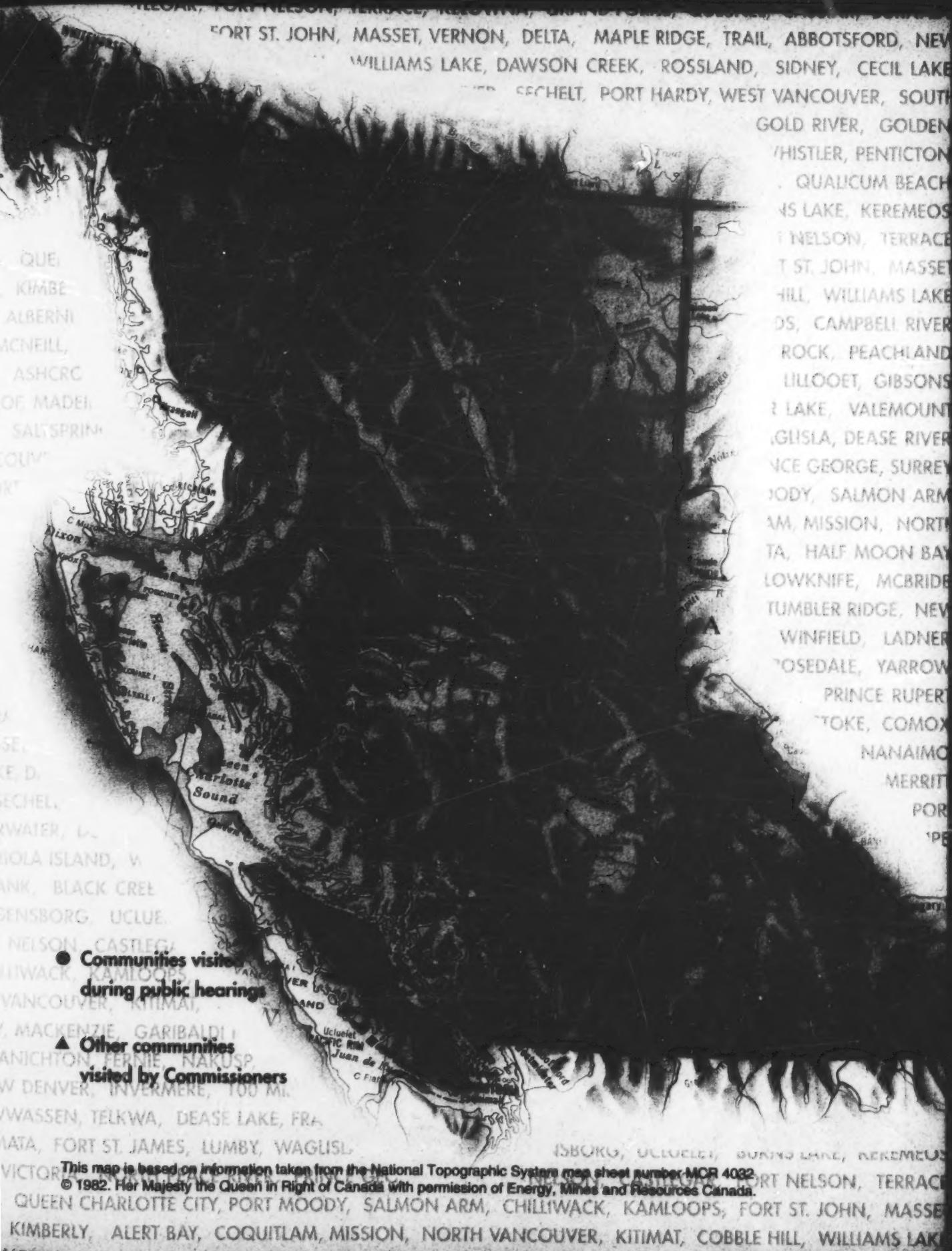
The health care system that this province and country have worked to build is part of that common wealth. It is one of the things that make us who we are. But the successes of medicare — the removal of financial barriers to care and the establishment of care as a right — can blind us to the possibilities inherent in new approaches to health.

We are faced with the challenge of determining the health requirements of a complex society. The challenges are not insurmountable. Building a more equitable and integrated system of care may be the greatest contribution British Columbians could make to the future of Canada.



Mr. Justice Peter D. Seaton, Chairman

on behalf of the commissioners.



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